kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

May 2012

How is the Affordable Care Act Leading to Changes in Medicaid Today? State Adoption of Five New Options

One primary goal of the Affordable Care Act (ACA) is to significantly reduce the number of uninsured through a Medicaid expansion and the creation of new health insurance exchanges. In addition, the law provides states a range of new opportunities and federal financing alternatives for their Medicaid programs. This brief provides an overview of five key Medicaid options provided by the ACA and state take up of these to date. As of May 2012, nearly every state (48 states and DC) has taken steps forward with at least one of the five options (Table 1). To date, most state participation has been in funding to upgrade Medicaid eligibility systems (28 states and DC) and test integrated care models for dual eligible beneficiaries (26 states).

1. **Getting an early start on the Medicaid expansion.** Starting April 2010 the ACA provided states a new state plan option to cover adults with incomes up to 133% FPL to get an early start on the 2014 Medicaid expansion. Since April 2010, eight states (CA, CT, CO, DC, MN, MO, NJ, WA) have received approval to expand Medicaid to adults early through the new option and/or a Section 1115 waiver.[1]
2. **Increased federal funding to upgrade Medicaid eligibility systems.** In April 2011, the federal government approved a temporary funding opportunity, under which states can receive a 90% federal funding match for the design, development, and implementation of major upgrades or new Medicaid eligibility systems, up from the regular 50% administrative matching rate. As of January 1, 2012, 29 states had approved or submitted plans to overhaul or build new systems, and most of the remaining states indicated interest in pursuing an upgrade during 2012.[2]
3. **New federal Medicaid funding for disease prevention.** Medicaid Incentives for Prevention of Chronic Disease (MIPCD), established by the ACA and administered by CMS, provides a total of $85 million over five years (January 1, 2011-December 31, 2015) to test the effectiveness of providing financial and non-financial incentives to Medicaid beneficiaries who participate in prevention programs and demonstrate changes in health risk and outcomes. As of January 1, 2012, ten states (CA, CT, HI, MN, MT, NH, NV, NY, TX, WI) received the first round of MIPCD grant awards.[3]
4. **Health homes for individuals with chronic conditions.** The ACA provides states with a new option to reform the delivery system for beneficiaries with chronic conditions by providing "health home" services and authorizes a temporary 90% federal match rate for these services. As of April 2012, CMS has approved six state plan amendments (SPA) in four states to provide health home services: two in MO; two in RI, one in NY, and one in OR. There are two additional health home SPAs under review in NC and WA, and CMS is reviewing draft proposals in five states (AL, IA, IL, OH, OK). In addition, CMS has approved funding requests from 15 states for planning activities to develop a health home SPA.[4]
5. **Integrating financing and care for dual eligible beneficiaries.** As provided by the ACA, in April 2011, the Center for Medicare and Medicaid Innovation, working with the CMS Medicare-Medicaid Coordination Office, awarded design contracts of up to $1 million each to 15 states to develop service delivery and payment models integrating care for beneficiaries dually eligible for Medicare and Medicaid.[5] In addition, as of April 2012, 26 states (including the 15 with design contracts) have submitted proposals to test models of integrated care and financing for dual eligible beneficiaries.[6]

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/kcmu

Table 1:
State Adoption of Five Key Medicaid Options Provided by the Affordable Care Act

State	Early expansion to cover adults[1]	Approved or submitted plan for Medicaid eligibility system upgrade[2]	Grant award for disease prevention[3]	Health Homes[4]		Dual Eligible Beneficiaries[5]	
				Approved or submitted SPA	Planning grant	Design contract award to integrate care	Proposal posted for financial alignment model
Total	**8**	**29**	**10**	**11**	**15**	**15**	**26**
Alabama		X		X	X		
Alaska		X					
Arizona		X			X		X
Arkansas					X		
California	X		X		X	X	X
Colorado	X					X	X
Connecticut	X		X			X	X
Delaware							
District of Columbia	X	X			X		
Florida							
Georgia		X					
Hawaii		X	X				X
Idaho					X		X
Illinois		X		X			X
Indiana							
Iowa		X		X			X
Kansas		X					
Kentucky		X					
Louisiana		X					
Maine					X		
Maryland		X					
Massachusetts		X				X	X
Michigan						X	X
Minnesota	X	X	X			X	X
Mississippi					X		
Missouri	X			X			X
Montana		X	X				
Nebraska							
Nevada		X	X		X		
New Hampshire		X	X				
New Jersey	X	X			X		
New Mexico		X			X		X
New York			X	X		X	X
North Carolina		X		X	X	X	X
North Dakota							
Ohio				X			X
Oklahoma		X		X		X	X
Oregon		X		X		X	X
Pennsylvania							
Rhode Island		X		X			X
South Carolina		X				X	X
South Dakota		X					
Tennessee						X	X
Texas		X	X				X
Utah							
Vermont		X				X	X
Virginia							X
Washington	X			X	X	X	X
West Virginia					X		
Wisconsin		X	X		X	X	X
Wyoming		X					

[1] As of May 2012. SPA Approved: CT, DC, MN; Waiver Approved: CA, CO, DC, MN, MO, NJ, WA.

[2] As of January 2012. Advanced Planning Document Approved: AL, AZ, GA, HI, IL, KS, KY, LA, MD, MA, MT, NV, NJ, NM, OK, OR, RI, SC, WY; Advanced Planning Document Submitted: AK, DC, IA, MN, NH, NC, SD, TX, VT, WI.

[3] As of January 2012

[4] As of April 2012. SPA Approved: MO, NY, OR, RI; SPA Under Review: NC, WA; Draft under review: AL, IL, IA, OH, OK.

[5] As of May 2012. Proposals posted/submitted for Managed FFS Model: CO, CT, IA, MO, NC, OK; Proposals posted/submitted for Capitated Model: AZ, HI, ID, IL, MA, MI, MN, NM, OH, OR, RI, SC, TN, TX, VT, VA, WI; Proposal posted/submitted for Both Models: CA, NY, WA.

Introduction

One primary goal of the Affordable Care Act (ACA) is to significantly reduce the number of uninsured through a Medicaid expansion and the creation of new health insurance exchanges. In addition, the law provides states a range of new opportunities and federal financing alternatives for their Medicaid programs. This brief provides an overview of five key Medicaid options provided by the ACA and state take up of these to date (Figure 1).

1. **Getting an early start on the Medicaid expansion.** Starting April 2010 the ACA provided states a new state plan option to cover adults with income up to 133% FPL to get an early start on the 2014 Medicaid expansion.

2. **Increased federal funding to upgrade Medicaid eligibility systems.** In April 2011, the federal government approved a temporary funding opportunity, under which states can receive a 90% federal funding match for the design, development, and implementation of major upgrades or new Medicaid eligibility systems.

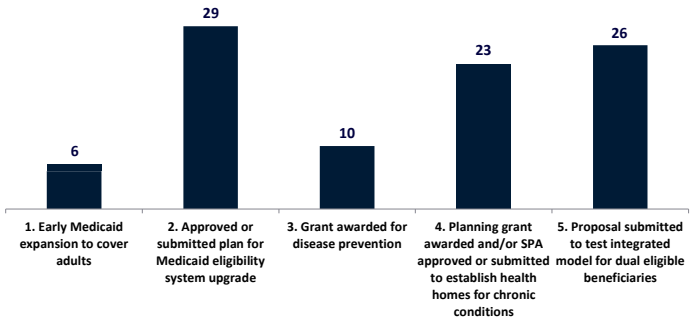
3. **New federal Medicaid funding for disease prevention.** Medicaid Incentives for Prevention of Chronic Disease (MIPCD), established by the ACA and administered by the Center for Medicare and Medicaid Services (CMS), provides a total of $85 million over five years (January 1, 2011- December 31, 2015) to test the effectiveness of providing financial and non-financial incentives to Medicaid beneficiaries who participate in prevention programs and demonstrate changes in health risk and outcomes.

4. **Health homes for people with chronic conditions.** The ACA provides states with a new option to reform the delivery system for beneficiaries with chronic conditions by providing "health home" services and authorizes a temporary 90% federal match rate for these services.

5. **Integrating financing and care for dual eligible beneficiaries.** As provided by the ACA, in April 2011, the Center for Medicare and Medicaid Innovation, working with the CMS Medicare-Medicaid Coordination Office, awarded design contracts of up to $1 million each to states to develop service delivery and payment models integrating care for beneficiaries dually eligible for Medicare and Medicaid.[7] In addition, in July 2011 CMS released a letter announcing new opportunities for states to test models of integrated care and financing for dual eligible beneficiaries.[8]

Figure 1

State Participation in Five Key Medicaid Options Provided by the Affordable Care Act



1. As of May 2012;
2. As of January 2012;
3. As of January 2012;
4. As of April 2012;
5. As of May 2012.

1. Getting an early start on the Medicaid expansion

One of the primary goals of the ACA is to decrease the number of uninsured through a Medicaid expansion to nearly all individuals with incomes up to 133% FPL ($14,856 for an individual or $30,656 for a family of four in 2012) and the creation of new health insurance exchanges. The Medicaid coverage expansion is expected to add an additional 17 million individuals to the program by 2016.[9]

To date, states have achieved significant success expanding Medicaid and CHIP coverage for children, but poor parents and other adults in many states remain ineligible for Medicaid.[10] This reflects the fact that the federal minimum Medicaid eligibility levels for parents are very low across states, and, prior to the ACA, states could not receive federal Medicaid matching funds to cover non-disabled adults without dependent children, regardless of their income. Because of their historic exclusion from Medicaid, states could only cover low-income adults in Medicaid by receiving a Section 1115 waiver of federal Medicaid rules and could not receive additional federal Medicaid funds for this coverage; instead, a state needed to finance the expansion by redirecting existing federal funds or with other program savings.

The ACA provided states a new state plan option, effective April 2010, to receive federal Medicaid matching funds to cover adults with incomes up to 133% FPL to get an early start on the 2014 Medicaid expansion.[11] States that expand coverage through the option must meet federal benefit and cost sharing requirements and cannot cap enrollment. In addition, subject to federal approval, states may still expand coverage to adults through a Section 1115 waiver and are no longer restricted from receiving additional federal Medicaid funds for this coverage. A state might seek to expand coverage through a Section 1115 waiver instead of the ACA state plan option to provide the coverage in ways that do not meet the rules for the state plan option, for example, by covering adults above 133% FPL, providing a more limited benefit package than otherwise allowed, or capping enrollment.[12]

Since April 2010, eight states have received approval to expand Medicaid to low-income adults through the new ACA option and/or Section 1115 waiver authority (Table 2). Together these expansions cover nearly 600,000 adults. Nearly all of these states previously covered some low-income adults through solely state- or county-funded programs.[13] By moving this coverage to Medicaid and securing federal financing, they were able to preserve and, in some cases, expand coverage for low-income adults. In addition, these states are gaining key experience reaching and enrolling low-income adults in Medicaid that will help them prepare outreach and enrollment processes for 2014.

Table 2:
States Getting an Early Start on the Medicaid Expansion, April 2010-May 2012

	Coverage Authority	Effective Date	Income Limit	Enrollment
CA	Waiver	Nov 1, 2010	200% FPL	251,308
CT	ACA Option	April 1, 2010	56% FPL	74,752
CO	Waiver	April 1, 2012	10% FPL	10,000
DC	ACA Option Waiver	July 1, 2010 Dec 1, 2010	133% FPL 200% FPL	40,776 3,411
MN	ACA Option Waiver	March 1, 2010 August 1, 2011	75% FPL 250% FPL	80,200 41,811
MO	Waiver	July 1, 2012	133% FPL	N/A
NJ	Waiver	April 14, 2011	23% FPL	53,490
WA	Waiver	Jan 3, 2011	133% FPL	50,920

Enrollment notes: CA: LIHP Dec. 2011 Monthly Enrollment, www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/EnrollmtLIHPDec11.pdf. CO: Enrollment is capped at 10,000 adults. MN: MA December 2011 Enrollment, https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6329-ENG Other data are based on communications with state officials. CT and DC are as of Jan. 2012; MO is scheduled to begin enrollment as of July 2012; coverage will be limited to St. Louis County. WA includes data for Basic Health transition eligible enrollees as of January 2012 and Medical Care Services transition eligible enrollees as of November 2011, see http://www.hca.wa.gov/hcr/waiver.html

2. Increased federal funding to upgrade Medicaid eligibility systems

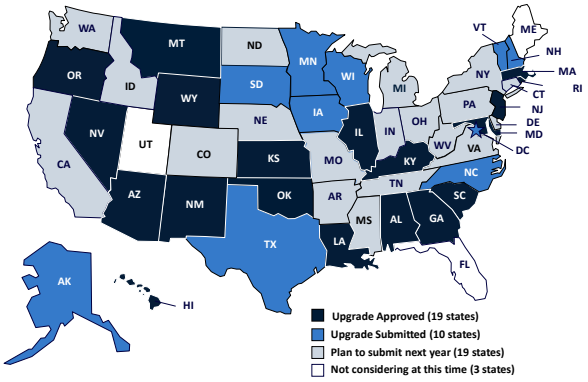
From online applications to verification of eligibility through electronic data exchanges to reaching more eligible children through Express Lane Eligibility, the use of technology is transforming how Medicaid and CHIP agencies do business. Over the past few years, states have continued to make incremental enhancements, but only a few have made sweeping overhauls to their eligibility and enrollment systems. The high cost of technology, coupled with state fiscal challenges, has prevented states from making the capital budget investments needed to replace their outdated systems.

In April 2011, the federal government approved a significant but temporary funding opportunity, known as the 90/10 rule, to support state investment in eligibility systems. Effective immediately and through 2015, states can receive a 90% federal funding match (up from the regular 50% match for administrative functions and systems) for the design, development, and implementation of major upgrades or new Medicaid eligibility systems.[14] The intent is to help states prepare for the ACA requirement for data-driven, online, paperless systems that will deliver real-time eligibility decisions. In addition, these advancements in technology provide program efficiencies, save administrative costs and time, and make it easier for eligible individuals to enroll in and retain coverage.

At a time when continued state budget pressures inhibit capital expenditures for systems development, the enhanced federal funding already has made a difference in states' willingness to launch major systems improvement projects. As of January 1, 2012, 19 states have received approval from CMS to overhaul or build new systems and an additional 10 states, including DC, have submitted plans (Figure 2).[15] Moreover, 19 of the remaining 22 states indicated interest in undertaking a system upgrade during 2012.[16] Among the five options examined in this analysis, the opportunity to make upgrades in Medicaid eligibility systems has had the most state participation to date, and has included states with varied positions related to implementation of other ACA provisions.

Figure 2

Status of Major Medicaid Eligibility System Upgrades, January 2012



NOTE: "Upgrade" pursued through an Expedited Advanced Planning Document(APD).
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

3. New federal Medicaid funding for disease prevention

Medicaid Incentives for Prevention of Chronic Disease (MIPCD), established by the ACA and administered by CMS, provides a total of $85 million over five years (January 1, 2011-December 31, 2015) in grants to states to test the effectiveness of providing financial and non-financial incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The purpose of the program is to evaluate the effect of the initiative on the use of health care services by Medicaid beneficiaries participating in the program; the extent to which special populations (including adults with disabilities, adults with chronic illnesses, and children with special health care needs) are able to participate in the program; the level of satisfaction of Medicaid beneficiaries with respect to the accessibility and quality of health care services provided through the program; and the administrative costs incurred by State agencies that are responsible for administration of the program.[17]

The programs must use relevant evidence-based research and resources and must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition. The incentives provided to a Medicaid beneficiary participating in this program cannot be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with federal funds.[18]

As of January 1, 2012 ten states (CA, CT, HI, MN, MT, NH, NV, NY, TX, WI) are the recipients of five-year grant funding, to be renewed annually and available until expended (Table 3). Of the $85 million available, $12 million is allocated for state administrative expenditures and $73 million for incentives to beneficiaries.[19]

Table 3:
Grants Awarded for Medicaid Incentives for Prevention of Chronic Disease Programs, January 2012

State	Grant Award	Prevention Goals				
		Tobacco Cessation	Controlling or Reducing Weight	Lowering Cholesterol	Lowering Blood Pressure	Avoiding Onset or Improving Management of Diabetes
CA	$1,541,583	X				
CT	$703,578	X				
HI	$1,265,988					X
MN	$1,015,076		X			X
MT	$111,791		X			X
NV	$415,606		X	X	X	X
NH	$1,669,800	X	X			
NY	$2,000,000	X			X	X
TX	$2,753,130	X	X	X	X	X
WI	$2,298,906	X				
Total	**$13,775,458**					

Source: CMS. MIPCD: The States Awarded. http://www.innovations.cms.gov/initiatives/MIPCD/states-awarded.html

4. Health homes for individuals with chronic conditions

The ACA provides states a new option to pursue person-centered systems of care designed to increase coordination by providing "health home" services for enrollees with chronic conditions. The health home model of service delivery expands on the traditional medical home models developed in many state Medicaid programs, by enhancing coordination and integration of physical and behavioral health care, and acute and long-term care, and by building linkages to community-based social services and supports. The aim of health homes is to improve health care quality and clinical outcomes as well as the patient care experience, while also reducing per capita costs through more cost-effective care.[20] For health home services specified in the law, the ACA authorized a temporary 90% federal match rate.

Table 4. Health Home Model Specifications

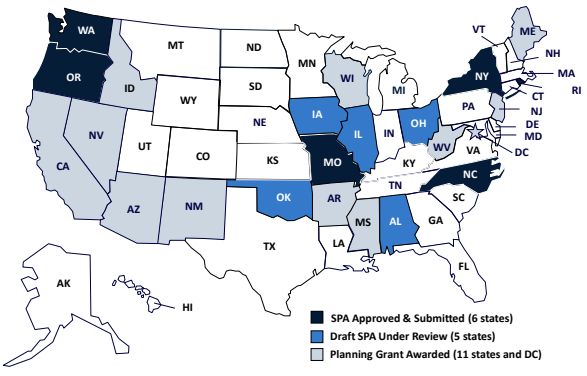
Health Home Services
• Comprehensive care management • Care coordination and health promotion • Transition care from inpatient to other settings • Individual and family support • Referral to community and social support services • Use of health information technology to link services
Chronic Conditions
• Mental health condition • Substance abuse disorder • Asthma • Diabetes • Heart disease • Overweight
Provider Arrangements
• Designated providers • Team of health care professionals that links to a designated provider • Health team

The ACA also specified a range of "health home" services and conditions (Table 4). To qualify for health home funding states must develop a model that is focused on beneficiaries with at least two chronic conditions; one condition and at risk of developing another; or at least one serious and persistent mental health condition. States pursuing the option can utilize one of three distinct types of health home provider arrangements.[21]

The health home state plan option became available to states on January 1, 2011. As of April 2012, CMS has approved six health home SPAs in four states: two in MO; two in RI, one in NY, and one in OR. Two additional SPAs, from NC and WA, are under review, and CMS is reviewing draft proposals submitted by AL, IA, IL, OH and OK (Figure 3).[22] CMS also has authorized states to spend up to $500,000 of Medicaid funding for planning related to the development of a health home SPA; state spending for this purpose will be matched at the state's regular matching rate. To date, CMS has approved health home planning requests from 15 states: AL, AZ, AR, CA, DC, ID, ME, MS, NV, NJ, NM, NC, WA, WV, WI.[23]

Figure 3

Status of Health Home SPAs or Planning Grants, April 2012



NOTE: AL, NC, and WA were also awarded health home planning grants.
SOURCE: Integrated Care Resource Center State-by-State Health Home State Plan Amendment Matrix. http://www.integratedcareresourcecenter.com/hhprogramdesign.aspx

5. Integrating financing and care for dual eligible beneficiaries

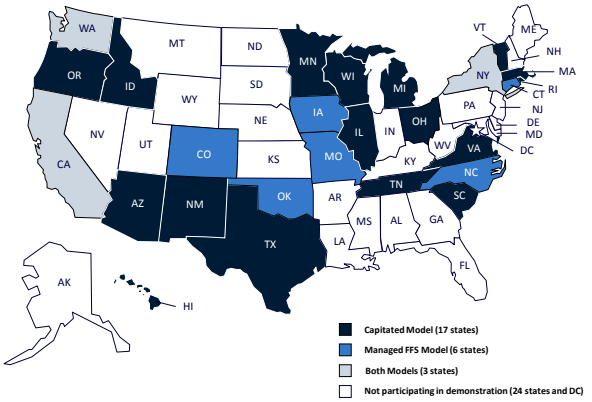
There are an estimated nine million dual eligible Medicare and Medicaid beneficiaries with complex medical and long-term care needs who account for a disproportionate share of spending in the two programs.[24] For example, dual eligible beneficiaries represent 20% of the Medicare population and 31% of Medicare program costs, and 15% of the Medicaid population and 39% of Medicaid program costs.[25]

The ACA established the Center for Medicare and Medicaid Innovation (CMMI), which in conjunction with the CMS Medicare-Medicaid Coordination Office (MMCO), awarded design contracts in April 2011 of up to $1 million each to 15 states to develop service delivery and payment models that integrate care for beneficiaries dually eligible for Medicare and Medicaid. The states include CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, and WI.[26] In addition, in July 2011, CMS released a "State Medicaid Director" letter containing preliminary guidance on new opportunities to align Medicare and Medicaid financing. It outlined a capitated integration model and a managed fee-for-service integration model that CMS proposed to test for full dual eligible beneficiaries in the 15 states participating in the design contracts as well as in other interested states.[27] In October 2011, CMS announced that 38 states (including the 15 that received design contracts) and the District of Columbia submitted letters of intent to potentially test its proposed financial alignment models for dual eligible beneficiaries.[28]

Over a period of twelve months these states have developed demonstration proposals to describe how they would "structure, implement and evaluate an intervention aimed at improving the quality, coordination and cost-effectiveness of care" for dual eligible beneficiaries, reaching out to a range of stakeholders in the process.[29] At the conclusion of the design phase, CMS will determine which of these states' proposals will move into the implementation phase, pending approval of the design and availability of funds.

Figure 4

Status of Dual Eligible Beneficiaries Integration Proposals, May 2012



SOURCE: National Senior Citizen Law Center. State Profiles. http://dualsdemoadvocacy.org/state-profiles

As of May 2012, 26 states have submitted proposals to test financial alignment models for dual eligible beneficiaries (Figure 4). Out of the 15 states awarded design contracts, MI, MN, NC, OK, WA, and WI have submitted their proposals to CMS, with their federal public comment periods still open; MA has submitted to CMS with their federal comment period closed. The remaining 8 states with design contracts have posted their proposals for the required state public comment period prior to CMS submission.[30] Of those states not awarded design contracts and interested in testing the financial alignment models, IL and OH have submitted their proposals to CMS with their federal comment periods closed; AZ, HI, ID, IA, MO, NM, RI, TX and VA have posted their proposals for state public comment periods.[31] Twelve states and DC have chosen not to pursue testing a financial alignment model at this time.

Conclusion

These five state Medicaid options provided by the ACA have given states new flexibility, opportunities, and federal resources to expand coverage, upgrade their information technology, test new models of care, and increase disease prevention and preventive care. Overall, nearly every state (48 states and DC) has taken steps forward on at least one of the five options. Among these five options, most state participation to date has been to make upgrades to Medicaid eligibility systems (28 states and DC), and has included states in varied states of preparing for the ACA coverage expansions. In addition, 26 states have submitted proposals to test integrated care models for dual eligible beneficiaries, an area of focus for state Medicaid programs over the last decade. Together, these opportunities are leading to changes in the Medicaid program that lay groundwork for the ACA coverage expansions and develop new systems of care for high cost beneficiaries.

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[11] States will receive 100% federal financing for "newly eligible" individuals (those not eligible for Medicaid when the ACA was enacted) for 2014-2016 and then this matching rate phases down to 90% by 2020 where it remains. States taking advantage of the early option for coverage will be able to draw down federal Medicaid matching funds at the regular Medicaid matching rate, but will still have access to the higher matching rate in 2104. For more details see: Kaiser Family Foundation. "Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and the States." May 2010. Available at: http://www.kff.org/healthreform/8072.cfm

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1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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